59

No. 06-1482

FILED
JUN 11 2007
OFFICE OF THE CLERK
SUPREME COURT, U.S.

In The
# Supreme Court of the United States

OKLAHOMA CHAPTER OF AMERICAN ACADEMY OF PEDIATRICS (OKAAP), ET AL.,

*Petitioners,*

v.

MICHAEL FOGARTY, CHIEF EXECUTIVE OFFICER OF THE OKLAHOMA HEALTH CARE AUTHORITY, ET AL.,

*Respondents.*

**On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Tenth Circuit**

## BRIEF OF RESPONDENTS IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

HOWARD J. PALLOTTA
Director of Legal Services
OKLAHOMA HEALTH CARE AUTHORITY
P.O. Drawer 18497
Oklahoma City, OK 73154-0497
Howard.pallotta@okhca.org
(405) 522-7431 Telephone
(405) 530-3440 Facsimile

*CHRISTOPHER J. BERGIN
Deputy General Counsel
OKLAHOMA HEALTH CARE AUTHORITY
P.O. Drawer 18497
Oklahoma City, OK 73154-0497
Christopher.bergin@okhca.org
(405) 522-7431 Telephone
(405) 530-3391 Facsimile

NICOLE M. NANTOIS
Deputy General Counsel
OKLAHOMA HEALTH CARE AUTHORITY
P.O. Drawer 18497
Oklahoma City, OK 73154-0497
Nicole.nantois@okhca.org
(405) 522-7431 Telephone
(405) 530-3439 Facsimile

**Counsel of Record*

COCKLE LAW BRIEF PRINTING CO. (800) 225-6964
OR CALL COLLECT (402) 342-2831

## QUESTIONS PRESENTED FOR REVIEW

1. DID THE COURT OF APPEALS ERR WHEN IT DECIDED THAT CONGRESS INTENDED THE WORD "MEDICAL ASSISTANCE" TO MEAN PAYMENT FOR MEDICAL CARE RATHER THAN TO REQUIRE THE STATE TO PROVIDE MEDICAL CARE REASONABLY PROMPTLY?

2. DID THE COURT OF APPEALS ERR WHEN IT DECIDED THAT CONGRESS DID NOT CREATE A PRIVATE RIGHT OF ACTION UNDER THE CIVIL RIGHTS ACT FOR METHODS AND PROCEDURES RELATING TO THE PAYMENT OF MEDICAID RATES UNDER 42 U.S.C. §1396a(a)(30)(A)?

3. DID THE COURT OF APPEALS ERR WHEN IT DECIDED THAT PETITIONER FAILED TO PRESERVE AN APPELLATE ISSUE REGARDING A CLAIM THAT 42 U.S.C. §1396a(a)(43) CREATES A PRIVATE RIGHT OF ACTION?

## PARTIES TO THE PROCEEDINGS

The Petitioners are:

Oklahoma Chapter of the American Academy of Pediatrics (OKAAP); Community Action Project of Tulsa County, Inc. (CAPTC); Katelyn M. Wilbanks, by her mother and next friend, Tracy Turner; Joshua Lee O'Neal, Eric Hartman Cammiso, Melissa Ann Padelford, and Matthew Scott Padelford, by their mother and next friend Lisa Padelford; Christy A. Towler, Katherine P. Towler, and Jacob W. Towler, by their parents and next friends Rowena Towler and Kevin Towler; Charles A. Scanlan and Robert M. Garvin, by their parents and next friends Janice Garvin and Theodore Garvin; Jacob W. Hercules and Everett L. Hercules, by their parents and next friends Regina Hercules and Gus Hercules; and Stephanie Moncrief, by her mother and next friend, Heather Brooke Rogers.

The Respondents are:

Michael Fogarty, Chief Executive Officer of the Oklahoma Health Care Authority (OHCA) (the governmental body that operates the Oklahoma Medicaid program); Lynn Mitchell, State Medicaid Director; Charles Ed McFall, Chairman of the OHCA Board of Directors; T.J. Brickner, Jr., Vice-Chair of the OHCA Board of Directors; Wayne Hoffman, Member of the OHCA Board of Directors; Jerry Humble, Member of the OHCA Board of Directors; Ronald Rounds, O.D., Member of the OHCA Board of Directors; George Miller, Member of the OHCA Board of Directors; Lyle Roggow, Member of the OHCA Board of Directors.

TABLE OF CONTENTS


| | Page |
|---|---|
| QUESTIONS PRESENTED FOR REVIEW | i |
| PARTIES TO THE PROCEEDINGS | ii |
| TABLE OF CONTENTS | iii |
| TABLE OF AUTHORITIES | v |
| INTRODUCTION | 1 |
| OPINIONS BELOW | 2 |
| JURISDICTION | 2 |
| STATUTORY PROVISIONS INVOLVED | 2 |
| STATEMENT OF THE CASE | 3 |
| A. STATUTORY AND REGULATORY BACKGROUND | 3 |
| B. PARTIES AND CLAIMS FOR RELIEF | 4 |
| C. MEDICAID RATES PAID AND ACCESS TO CARE | 5 |
| D. ANALYSIS AND DECISION BY THE TRIAL COURT | 7 |
| E. COURT OF APPEALS DECISION | 8 |
| ARGUMENT | 10 |
| I. THIS COURT SHOULD NOT GRANT CERTIORARI BECAUSE THE COURT OF APPEALS CORRECTLY DECIDED THAT THE TERM "MEDICAL ASSISTANCE" MEANS "PAYMENT FOR CARE" AND NOT THE ACTUAL PROVISION OF CARE; THE COURT FOLLOWED TIME HONORED RULES OF CONSTRUCTION | 10 |

TABLE OF CONTENTS – Continued

Page

II. THIS COURT SHOULD NOT GRANT CERTIORARI BECAUSE THERE IS NO DECISIONAL CONFLICT BETWEEN COURTS OF APPEALS REGARDING THE PRIVATE ENFORCEABILITY OF 42 U.S.C. §1396a(a)(30)(A) ..... 12

III. THIS COURT SHOULD NOT GRANT CERTIORARI BECAUSE THE COURT OF APPEALS CORRECTLY FOUND THAT ERROR WAS NOT PRESERVED REGARDING A PRIVATE RIGHT OF ACTION UNDER 42 U.S.C. §1396a(a)(43) ..... 15

IV. THIS COURT SHOULD NOT GRANT CERTIORARI BECAUSE CERTIORARI WAS DENIED IN AN IDENTICAL CASE FROM THE TENTH CIRCUIT TWO MONTHS BEFORE THIS PETITION WAS FILED ..... 16

CONCLUSION ..... 17

# TABLE OF AUTHORITIES

Page

CASES

*Blessing v. Freestone*, 520 U.S. 329, 117 S.Ct. 1353, 137 L.Ed. 2d 569 (1997) ..... 13

*Bruggeman v. Blagojevich*, 324 F.3d 906 (7th Cir. 2003) ..... 10, 12

*Doe v. Chiles*, 136 F.3d 709 (11th Cir. 1998) ..... 10

*Gonzaga University v. Doe*, 536 U.S. 273, 122 S.Ct. 2268, 153 L.Ed. 2d 309 (2002) ..... 9, 13, 14, 15

*Hamilton-Brown Shoe Co. v. Wolf Brothers & Co.*, 240 U.S. 251, 36 S.Ct. 269, 60 L.Ed. 629 (1916) ..... 16

*Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50 (1st Cir. 2004) ..... 14

*Mandy R. v. Owens*, 464 F.3d 1148 (10th Cir. 2006) ..... 14, 15

*Mandy R. v. Ritter*, 127 S.Ct. 1905, 167 L.Ed. 2d 364, 75 U.S.L.W. 3511 (2007) ..... 16

*OKAAP v. Fogarty*, 472 F.3d 1208 (10th Cir. 2007) ..... 2, 8, 15

*Pediatric Specialty Care v. Arkansas Department of Human Services*, 443 F.3d 1005 (8th Cir. 2006) ..... 14

*Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005) ..... 14

*Sorenson v. Secretary of Treasury*, 475 U.S. 851, 106 S.Ct. 1600, 89 L.Ed. 2d 855 (1986) ..... 11

*Springfield v. Kibbe*, 480 U.S. 257, 107 S.Ct. 1114, 94 L.Ed. 2d 293 (1987) ..... 16

*St. Louis v. Praprotnik*, 485 U.S. 112, 108 S.Ct. 915, 99 L.Ed. 2d 107 (1988) ..... 16

TABLE OF AUTHORITIES – Continued

Page

*Sullivan v. Stroop,* 496 U.S. 478, 110 S.Ct. 2499, 110 L.Ed. 2d 438 (1990) ..... 11

*United States v. Jackson,* 280 U.S. 183, 50 S.Ct. 143, 74 L.Ed. 361 (1930) ..... 11

*Westside Mothers v. Olszewski,* 454 F.3d 532 (6th Cir. 2006) ..... 12, 13

*Will v. Mich. Dep't of State Police,* 491 U.S. 58, 109 S.Ct. 2304, 105 L.Ed. 2d 45 (1989) ..... 11

*Wilder v. Virginia Hospital Association,* 496 U.S. 498, 110 S.Ct. 2510, 110 L.Ed. 2d 455 (1990) ..... 14

STATUTES AND RULES

42 C.F.R. §206.10(a)(3) (1971) ..... 12

42 C.F.R. §206.10(a)(6) (1971) ..... 12

42 C.F.R. §435.911, 930(a)-(b) ..... 10

45 C.F.R. §206.10(a)(6) ..... 12

36 F.R. 3860 (February 27, 1971) ..... 12

38 F.R. 3380 (December 3, 1973) ..... 12

28 U.S.C. §1254(1) ..... 2

28 U.S.C. §2101(c) ..... 2

42 U.S.C. §1396a ..... 3

42 U.S.C. §1396a(a)(8) ..... *passim*

42 U.S.C. §1396(a)(10) ..... *passim*

42 U.S.C. §1396a(a)(30) ..... 9

42 U.S.C. §1396a(a)(30)(A) ..... *passim*

42 U.S.C. §1396a(a)(43) ..... *passim*

TABLE OF AUTHORITIES – Continued

Page

42 U.S.C. §1396d(a) ..... 1, 2, 3, 9

42 U.S.C. §1396d(a)(1)-(5), (17), (21) ..... 3

42 U.S.C. §1396d(r) ..... 2

42 U.S.C. §1983 ..... 2, 4, 13

Sup. Ct. Rule 10 ..... 12, 13

Sup. Ct. Rule 13.3 ..... 2

## INTRODUCTION

A class of Medicaid members and pediatricians, along with a social service agency, received mandatory permanent injunctive relief against the State Medicaid agency in Oklahoma for a violation of civil rights under the Medicaid Act. After acknowledging that the statutory definition of medical assistance referred to payment, the trial court; nevertheless, determined that Oklahoma had failed to provide reasonably prompt care to children served by Medicaid. This determination was made despite Oklahoma's national reputation as a medically underserved area of the country. The Medicaid Act was intended as a payment scheme and does not require Oklahoma to provide medical care, conduct medical screenings, or insure that patients have prompt medical appointments.

The Court of Appeals reversed the mandatory permanent injunction; finding that the definition of medical assistance contained in the Medicaid Act, at 42 U.S.C. §1396d(a), required State Medicaid agencies to promptly (or timely) reimburse providers for medical care, but not to actually provide that care. The Court of Appeals correctly interpreted the Act, deciding that 42 U.S.C. §1396a(a)(30)(A) did not create a private right of action on behalf of members, pediatricians or social service agencies to file suit to insure care was delivered promptly or to force the State to act as a medical service provider.

The Circuit Court further found that failure to preserve the question of a private right of action stemming from 42 U.S.C. §1396a(a)(43) placed that issue beyond their review.



## OPINIONS BELOW

*Oklahoma Chapter of the Academy of Pediatrics (OKAAP) v. Fogarty*, 472 F.3d 1208 (10th Cir. 2007) ("OKAAP APPEAL"), Pet. App. at 3a.

*Oklahoma Chapter of the American Academy of Pediatrics (OKAAP) v. Fogarty*, 366 F.Supp. 2d 1050 (N.D. Okla. 2005) (contains the District Court's Findings of Fact and Conclusions of Law) ("OKAAP TRIAL"), Pet. App. at 32a.

*Oklahoma Chapter of the American Academy of Pediatrics (OKAAP) v. Fogarty*, N.D. Okla. May 19, 2005 ("OKAAP INJUNCTION") (contains the District Court's Final Judgment and Final Injunction and is not reported), Pet. App. at 22a.

## JURISDICTION

Based upon 28 U.S.C. §1254(1) this Court has proper jurisdiction of this case. Under 28 U.S.C. §2101(c) and Supreme Court Rule 13.3, this case was required to be filed no later than ninety days from the denial of rehearing in this case. Rehearing was denied on February 13, 2007. The Petition for Certiorari was timely filed on May 7, 2007.

## STATUTORY PROVISIONS INVOLVED

The statutory provisions at issue in this case are: 42 U.S.C. §1983, 42 U.S.C. §§1396a(a)(8), (a)(10), (a)(30)(A), (a)(43), 42 U.S.C. §1396d(a), and 42 U.S.C. §1396d(r).

## STATEMENT OF THE CASE

### A. STATUTORY AND REGULATORY BACKGROUND

The Medicaid Act was promulgated by Congress in 1965 as Title XIX of the Social Security Act. The grant program's structure consists of a number of requirements mandated to the participating states in order for them to receive federal financial participation. With program approval retained by the Federal government, each state develops a "State plan for medical assistance." 42 U.S.C. §1396a. A state plan which omits a required element will not be approved for contribution of Federal funds. For example, to determine eligibility under the jointly federal-state program the plan must, "provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals." 42 U.S.C. §1396a(a)(8). The contents of the plan must show how the state will, "(10) provide – (A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17) and (21) of section 1905(a) [42 U.S.C. §§1396d(a)(1)-(5), (17) and (21)]. . . ." 42 U.S.C. §1396a(a)(10). The contents of the plan must, "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . " 42 U.S.C. §1396a(a)(30)(A). The plan's content must, provide for informing, providing or arranging, and reporting to the secretary certain members who have requested early and periodic screening, diagnostic and treatment services. 42 U.S.C. §1396a(a)(43).

All of the provisions of the Medicaid Act are governed by the definition of the term medical assistance. This definition is found at 42 U.S.C. §1396d(a) and provides,

"For purposes of this title . . . (a) Medical assistance. The term "medical assistance" means payment of part or all of the cost of the following care and services. . . ."

## B. PARTIES AND CLAIMS FOR RELIEF

This factually complex case involves a §1983 claim by a class of Medicaid children,[1] a class of pediatricians (the Oklahoma Chapter of the American Academy of Pediatrics) and a social service agency (Community Action Project of Tulsa County). Pet. App. at 32a-33a. The claims at the trial were threefold; (1) failure to provide sufficient rates to pediatricians; (2) failure to comply with provisions of the Medicaid Act regarding Early, Periodic, Screening, Diagnosis and Testing (hereinafter referred to as EPSDT); and, (3) the creation of other barriers for pediatricians in providing care to Medicaid beneficiaries. Pet. App. at 25a. The claims for relief involved several Medicaid Act provisions found at 42 U.S.C. §§1396a(a)(8), (a)(10), (a)(30)(A), and (a)(43). While the claims at trial involved system-wide defects in the entire Medicaid system,[2] three issues consumed trial court deliberations;

(1) rates paid to pediatricians and physician specialties,

(2) delays in care to patients,

(3) EPSDT screening services.

---

[1] The class representatives comprise 13 children and their parents.

[2] Complaints were unsuccessfully lodged concerning auto-assignments of members to pediatricians when members failed to choose a physician, the drugs covered under the Medicaid program, the reporting of EPSDT screens, and the supervision of alleged poor medical care. Pet. App. at 25a-26a, 33a, 163a.

## C. MEDICAID RATES PAID AND ACCESS TO CARE

At the time of trial[3] Oklahoma delivered physician care utilizing a primary care partially capitated model (PCCM) pursuant to a Medicaid Section 1115 Waiver. Pet. App. at 39a. It used primary care physicians (allopathic and osteopathic) and nurse practitioners to deliver a case-management evaluation set of services in return for a monthly fee based on the number of members on the primary care physicians' roster of Medicaid patients. Pet. App. at 47a, 80a. The payment to the primary care physician was not dependent upon who was seen by the doctor during the month. If a Medicaid member needed additional specialty services (orthopedic, internal medicine, neurological), the primary care physician referred the member to a specialist. The specialist was not paid on a capitation basis; but, on a fee-for-service basis. Pet. App. at 46a. At the time of the trial, primary care physicians were paid an average of $17.00 to $27.00 per month, per member (dependant on the member's age classification and eligibility category). Res. App. at 20-21. With a panel of 500 members, a primary care physicians would earn between $102,000.00 and $162,000.00 per year (500 x 30 x $17.00 or $27.00), as a base payment. Additional payments were made to primary care physicians for services provided which fell outside of the capitation service package. Specialists were paid an average of 90% of the Medicare

---

[3] Petitioners claims spanned from 1995 to 2001 Oklahoma changed its Medicaid delivery system from a fully capitated model to a partial capitation model in January 2004. Data concerning the fully capitated model was irrelevant to the trial court and the Court of Appeals. Pet. App. at 39a-40a.

fee schedule for evaluation and management codes,[4] and 72% of the Medicare fee schedule for the rest of the codes. Pet. App. at 46a. At the time of trial, Oklahoma had received federal authority to pay University employed physicians at a rate of 140% of the Medicare fee schedule. Pet. App. at 82a.

While it is necessary to understand Oklahoma's payment methods, it is also important to understand the limited supply of physicians available in Oklahoma. At trial, both parties acknowledged that Oklahoma was a medically underserved area and the availability of specialty physicians was a chronic problem for all Oklahomans. To illustrate, the availability of primary care physicians for the average Medicaid recipient consisted of five (5) doctors within a 10.9 mile radius of home or five (5) pediatricians within a 35.5 mile drive. Pet. App. at 41a, Res. App. at 1-2. Significant shortages of medical specialists were noted by the trial court. To serve over 1 million children in Oklahoma (of which 348,000 were Medicaid eligible children) there are: four (4) pediatric neurologists in Oklahoma, five (5) or six (6) pediatric orthopedists, ten (10) or twelve (12) child psychiatrists, six (6) pediatric surgeons, and one hospital in the state which is staffed with pediatric emergency rooms physicians. Pet. App. at 59a-60a, 64a, 66a, 71a, 69a; Trial Tran. at XIV at 1862:3-18; 1863:19-55.

---

[4] Evaluation and Management codes are those codes in which a physician uses in most first office visits to evaluate the problem with the patient. Evidence at trial showed these codes were used most often by specialists.

## D. ANALYSIS AND DECISION BY THE TRIAL COURT

The trial took 19 days in April and May of 2004. The trial Court's Findings of Fact and Conclusions of Law numbered 129 pages and were filed on March 22, 2005. To determine whether the "equal access" provision of 42 U.S.C. §1396a(a)(30)(A) had been violated as well as whether Oklahoma had violated the section (a)(8) requirement of "reasonably prompt" care, the trial court examined eight factors regarding both the supply of physicians and the demand for physician services. Pet. App. at 135a-142a. The court considered: (1) Congress' intent regarding the term "available" to the general population, Pet. App. at 135a; (2) the definition of the term "geographic access", Pet. App. at 136a; (3) whether the statute requires the state to have a specific method to have sufficient payments, or whether just a substantive result is required; (4) what the term access meant,[5] Pet. App. at 138a-140a; (5) comparisons between the state's reimbursement and Medicare payments for the same services, Pet. App. at 141a; (6) whether recipients waited "unreasonable periods of time" to receive care, Pet. App. at 141a; (7) whether providers were widely opting out, Pet. App. at 142a; and (8) whether for children with complex needs it is medically appropriate for children to receive care from anyone other then a pediatrician. Pet. App. at 142a-143a. This analysis led to the conclusion by the trial court that Oklahoma had violated 42 U.S.C. §1396a(a)(8), (a)(10), (a)(30)(A). Pet. App. at 25a.

---

[5] Significantly, the trial court found that Oklahoma's Medicaid program must contract to have 2/3 of all physicians fully participating in the program. Pet. App. at 140a.

With regard to the claims of delay of care, the trial court found that the Oklahoma Health Care Authority had violated the Medicaid Act subsections (a)(8) and (a)(10). Pet. App. at 146a. The trial court reasoned that while Medicaid involved "financial assistance", that "[w]ithout financial assistance (provider reimbursement) sufficient to attract an adequate number of providers, reasonably prompt assistance is effectively denied." *OKAAP v. Fogarty*, 472 F.3d 1208, 1214-1215 (10th Cir. 2007). Pet. App. at 17a and 147a.

To remedy these violations the trial court ordered Oklahoma to raise its payment rates to 100% of the Medicare rate for all services provided to children, to hire an expert consultant to study the sufficiency of payments for 16 different specialties, to use the expert's report to update its rates, and to exceed the Medicare rate, if necessary, to achieve equal access to services. Pet. App. at 8a-10a.

Significantly, the trial court found that OKAAP did not have a private right of action under 42 U.S.C. §1396a(a)(30)(A) and also found that Oklahoma had substantially complied with the requirements to provide EPSDT services under 42 U.S.C. §1396a(a)(43). Pet. App. at 25a.

## E. COURT OF APPEALS DECISION

Oklahoma raised its payments to all physicians to 100% of the Medicare rate for all recipients, and appealed the trial court's order to the Tenth Circuit Court of Appeals in a cross appeal to the Plaintiffs' appeal. Plaintiffs alleged the trial court's Order was not prescriptive enough and failed to order monitoring of the system. Pet. App. at 11a,

19a. Defendants alleged the trial court incorrectly analyzed *Gonzaga v. Doe* and its progeny regarding Congressional intent to create a private right of action. Pet. App. at 17a-18a. Oklahoma argued that the Medicaid Act was not intended to mean States must "provide care."

On January 3, 2007, after supplemental briefing by both parties to the Circuit, the Court of Appeals issued a decision reversing the holding on all claims of the district court. The Circuit found that the definition of "medical assistance" in 42 U.S.C. §1396d(a) made Medicaid a payment program. As such, there was no congressional intent to require the states to provide "prompt care", or "make medical assistance" by providing medical services promptly. Pet. App. at 17a-18a. The Court of Appeals found that there was no private right of action under 42 U.S.C. §1396a(a)(30). Pet. App. at 20a. The Tenth Circuit rejected Petitioner's claims that it had properly raised arguments on appeal regarding whether the Medicaid Act created a private right of action regarding EPSDT requirements. Pet. App. at 20a. Petitioners request for rehearing was denied on February 5, 2007. Res. App. at 3-4. Petitioners filed a Petition for Certiorari on May 7, 2007.

## ARGUMENT

### I. THIS COURT SHOULD NOT GRANT CERTIORARI BECAUSE THE COURT OF APPEALS CORRECTLY DECIDED THAT THE TERM "MEDICAL ASSISTANCE" MEANS "PAYMENT FOR CARE" AND NOT THE ACTUAL PROVISION OF CARE; THE COURT FOLLOWED TIME HONORED RULES OF CONSTRUCTION

The Tenth Circuit's interpretation of the term "medical assistance" was simple, but correctly applied several rules of statutory construction. The court reviewed the statutory enactments in three sections of the Act. It reviewed the specific definition Congress gave the term "medical assistance." The court reviewed the Seventh Circuit's decision in *Bruggeman v. Blagojevich,* 324 F.3d 906 (7th Cir. 2003). The court noted that in its view that if the district court were correct in its determination that Oklahoma was responsible for prompt appointments that, "it would broaden *§1396a(a)(8)* far beyond its intended scope, and would require federal courts to engage in what the Third Circuit has described as the "onerous" task of evaluating whether a state's Medicaid reimbursement rates are 'reasonable and adequate.'" *OKAAP v. Fogarty*, 472 F.3d 1208, 1214-1215 (10th Cir. 2007) (citing *Doe v. Chiles*, 136 F.3d 709, 717 (11th Cir. 1998)). The court reviewed the regulatory treatment of subsection a(8) by reviewing federal regulations regarding the section. *OKAAP v. Fogarty,* 472 F.3d at 1214 (10th Cir. 2007) (reviewing 42 C.F.R. §435.911, 930(a)-(b)). Res. App. at 5-6.

The Court of Appeals' analysis is consistent with this Court's rules of statutory interpretation. For example, if Congress intends to alter the usual constitutional balance between the states and the federal government, it must

make its intention to do so clearly and unambiguously. *Will v. Mich. Dep't of State Police*, 491 U.S. 58, 65, 109 S.Ct. 2304, 2309, 105 L.Ed. 2d 45, 54 (1989). It is a normal rule of statutory construction that if the same word is used throughout a statutory enactment, then it must be given a standard meaning. *Sorenson v. Secretary of Treasury*, 475 U.S. 851, 860, 106 S.Ct. 1600, 1606, 89 L.Ed. 2d 855, 865 (1986). Where a statute appears to have a word of art, then any attempt to break down the word will likely not illuminate it. *Sullivan v. Stroop*, 496 U.S. 478, 483, 110 S.Ct. 2499, 2503, 110 L.Ed. 2d 438, 445 (1990). Finally, it is a familiar rule of statutory construction that great weight is properly to be given to the construction consistently given to a statute by the executive department charged with its administration. *United States v. Jackson*, 280 U.S. 183, 193, 50 S.Ct. 143, 146, 74 L.Ed. 361, 366 (1930).

The Court of Appeals correctly noted that the district court's interpretation of the Act would broaden in scope the nature of the federal-state relationship. If Congress intended the states to directly provide medical care, insure quick appointment times, and to medically screen children, then the language of this federal grant program should unambiguously state such intention. The Court noted that the same word, namely "medical assistance", is used in both subsections (a)(8) and (a)(10) as well as the definitional section. Thus, the Court applied a standard definition each time using the normal rule of statutory construction. The Court noted that the definition of "medical assistance" is a term of art, as it is defined specially. Changing the word's meaning from section to section would not "illuminate it." The Circuit noted that the executive department's treatment of the term "furnishing

medical assistance" was consistent with the payment of monies. *See* 45 C.F.R. §206.10(a)(3) (1971) at 36 F.R. 3860 (February 27, 1971) (noting changes in federal regulations); 38 F.R. 3380 (December 3, 1973) (changing 45 C.F.R. §206.10(a)(6) (entitlement begins with payment)). Res. App. at 7-17.

Moreover, the Tenth Circuit's ruling in the case is consistent with both the Sixth and Seventh Circuit Courts. The Sixth Circuit has also held that in §1396a(a)(8), the term "medical assistance" means that a state must only provide financial assistance. In *Westside Mothers v. Olszewski*, 454 F.3d 532, 540 (6th Cir. 2006), the Court stated that "Medicaid Act clearly defines the "term medical assistance" in §1396(a)(8) and (10). Medical assistance means payment of all or part of the cost of services for eligible Medicaid recipients under the age of 21." *Westside Mothers v. Olszewski*, 454 F.3d at 540 (6th Cir. 2006). In *Bruggeman v. Blagojevich,* 324 F.3d at 910, the Seventh Circuit Court found that the term "assistance" was defined as financial assistance not medical services.

For all of these reasons, the Court of Appeals construction of the statute was proper. For this reason none of the considerations in Supreme Court Rule 10 are present in this case.

## II. THIS COURT SHOULD NOT GRANT CERTIORARI BECAUSE THERE IS NO DECISIONAL CONFLICT BETWEEN COURTS OF APPEALS REGARDING THE PRIVATE ENFORCEABILITY OF 42 U.S.C. §1396a(a)(30)(A)

Supreme Court Rule 10 states that the Court will only grant a petition for writ of certiorari for compelling reasons. Rule 10 further delineates the type of issues the

Court considers when granting certiorari. None of the compelling issues contained in Rule 10 are present here. Petitioners allege that a split exists in the Circuit Courts regarding a private right of action through §1983 and 42 U.S.C. §1396a(a)(30)(A). However, no split exists among the Circuit Court of Appeals regarding whether 42 U.S.C. §1396a(a)(30)(A) creates a private right of action.

In *Blessing v. Freestone*, 520 U.S. 329, 117 S.Ct. 1353, 137 L.Ed. 2d 569 (1997), the Court held that in order for a plaintiff to seek redress under §1983 there must be a violation of a federal right. A violation of a federal law is not enough for a plaintiff to recover under §1983. A statutory provision will allow a private right of action if three criteria are met. The first criteria is that Congress must have intended that the provision in question benefit the plaintiff. *Blessing v. Freestone*, 520 U.S. at 340-341. After *Blessing v. Freestone*, 520 U.S. at 340-341, the Court went on to restrict further the first requirement in *Gonzaga University v. Doe*, 536 U.S. 273, 122 S.Ct. 2268, 153 L.Ed. 2d 309 (2002). An enforceable private right only exists if the statute is unambiguous in granting the right. The statute will not confer a private right when the statute is a vague benefit. *Gonzaga v. Doe*, 536 U.S. at 283-284.

Since the Supreme Court's ruling in *Gonzaga*, five Circuit Courts have considered whether 42 U.S.C. §1396a(a)(30)(A) creates a private enforceable right. Four Circuits have decided no private right of action was created by Congress. In *Westside Mothers v. Olszewski*, 454 F.3d 532, 542-543 (6th Cir. 2006), the Court found that §1396a(a)(30)(A) did not focus on individual entitlements but rather on an aggregate focus. The language is broad and nonspecific and fails the first prong of the *Blessing*

test. The Ninth Circuit stated that the language of §1396(a)(30)(A) does not focus on an individual's rights and its broad language is not amenable to a judicial remedy. *Sanchez v. Johnson*, 416 F.3d 1051, 1060-1061 (9th Cir. 2005). The Court in *Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 57 (1st Cir. 2004), found that no enforceable private right of action existed for providers under §1396a(a)(30)(A) holding that the statute does not have "right's creating language and does not identify a specific class of beneficiaries." Finally, the Tenth Circuit has held that §1396a(a)(30)(A) does not confer an enforceable private right on identifiable beneficiaries. The Court stated, "We join the First, Sixth and Ninth Circuits in concluding that subsection (30)(A) does not create a federal right enforceable under §1983 . . . Recipients and providers surely benefit from efficient Medicaid administration, for example, as taxpayers generally, but subsection (30)(A) never establishes an 'identifiable class' of rights-holders." *Mandy R. v. Owens*, 464 F.3d 1148 (10th Cir. 2006).

The Eighth Circuit is the only Circuit Court to hold that §1396a(a)(30)(A) creates an enforceable private right. In *Pediatric Specialty Care v. Arkansas Department of Human Services*, 443 F.3d 1005 (8th Cir. 2006) the Court found a private right of action for providers and recipients. The court relied on its own precedent and stare decisis in both *Gonzaga v. Doe*, supra, and *Wilder v. Virginia Hospital Association*, 496 U.S. 498, 110 S.Ct. 2510, 110 L.Ed. 2d 455 (1990) (interpreting a section of the Medicaid Act that has subsequently been repealed).

The Court did not examine the text to find the rights creating language as required by *Gonzaga v. Doe*, supra. Rather, it decided that the test in *Gonzaga* was met

because the beneficiaries are Medicaid payment recipients and the scope of the statute was clear. In *Mandy R. v. Owens*, supra, the Tenth Circuit correctly disagreed with the Eighth Circuit's holding.

Based upon the decisions by the federal circuits since this Court's decision in *Gonzaga v. Doe*, supra, there is no split in the circuits regarding this issue. One case decision does not create a split among circuits.

## III. THIS COURT SHOULD NOT GRANT CERTIORARI BECAUSE THE COURT OF APPEALS CORRECTLY FOUND THAT ERROR WAS NOT PRESERVED REGARDING A PRIVATE RIGHT OF ACTION UNDER §1396a(a)(43)

In proposition II B, the Petitioners assert that the Court of Appeals' reading of subsection a(a)(43) (the subsection regarding EPSDT) was erroneous. This argument should not be considered because this issue was not properly preserved by the Petitioners before the Tenth Circuit Court of Appeals. In supplemental briefing in the Court of Appeals, Petitioners attempted, for the first time, to raise the issue of whether 42 U.S.C. §1396a(a)(43) creates a private right of action for Medicaid members.[6] The Court of Appeals rejected this argument stating that, "We conclude these arguments are not properly before us. Absent authorization from this court, a party is generally precluded from raising issues in a supplemental brief that were not addressed in an opening brief." *OKAAP v. Fogarty*, 472 F.3d 1208, 1216 (10th Cir. 2007) (citations

[6] The Petitioners did not assert the alleged right belonged to pediatricians or social service agencies.

omitted). The Court of Appeals also concluded that this same issue was not addressed or decided by the trial court.

Supreme court jurisprudence has concluded that the failure to raise or preserve an error is a reason to deny certiorari. *Springfield v. Kibbe*, 480 U.S. 257, 259, 107 S.Ct. 1114, 1115, 94 L.Ed. 2d 293, 298 (1987); *Hamilton-Brown Shoe Co. v. Wolf Brothers & Co.*, 240 U.S. 251, 258, 36 S.Ct. 269, 271, 60 L.Ed. 629, 633 (1916) but *see St. Louis v. Praprotnik*, 485 U.S. 112, 120, 108 S.Ct. 915, 922, 99 L.Ed. 2d 107, 116 (1988). Because this issue was not decided by either the trier of fact or the appeals court, this Court should deny certiorari.

## IV. THIS COURT SHOULD NOT GRANT CERTIORARI BECAUSE CERTIORARI WAS DENIED IN AN IDENTICAL CASE FROM THE TENTH CIRCUIT TWO MONTHS BEFORE THIS PETITION WAS FILED

On March 26, 2007, the Supreme Court denied a Petition for Writ of Certiorari in *Mandy R. v. Ritter*, ___ U.S. ___, 127 S.Ct. 1905, 167 L.Ed. 2d 364 (2007). The main issues decided by the Tenth Circuit Court of Appeals in *Mandy R.*, supra, are identical to the issues in this case at bar. Both cases were decided by the Court of Appeals. The Circuit concluded in both cases that 42 U.S.C. §1396a(a)(30)(A) does not create an enforceable private right. Further, the Circuit concluded in both cases that with regard to 42 U.S.C. §1396a(a)(8) medical assistance means paying for care rather than providing actual medical services. No intervening case law has been decided in the last two months between the denial of certiorari on *Mandy R. v. Ritter,* and the filing of the Petition in this case on May 7, 2007.

## CONCLUSION

Certiorari should be denied for four reasons. First, the Court of Appeals correctly ruled that the term of art "medical assistance" means payment for services. Second, there is no decisional conflict between the Courts of Appeals regarding the private enforceability of 42 U.S.C. §1396a(a)(30)(A). Third, Petitioner's did not properly preserve issues regarding 42 U.S.C. §1396a(a)(43) before the Court of Appeals. No analysis or reasoning has been performed regarding this statute for the Court to review. Fourth, certiorari was denied by this Court in an identical case in March, 2007.

Respectfully submitted,

HOWARD J. PALLOTTA
Director of Legal Services
OKLAHOMA HEALTH
CARE AUTHORITY
P.O. Drawer 18497
Oklahoma City, OK 73154-0497
Howard.pallotta@okhca.org
(405) 522-7431 Telephone
(405) 530-3440 Facsimile

*CHRISTOPHER J. BERGIN
Deputy General Counsel
OKLAHOMA HEALTH
CARE AUTHORITY
P.O. Drawer 18497
Oklahoma City, OK 73154-0497
Christopher.bergin@okhca.org
(405) 522-7431 Telephone
(405) 530-3391 Facsimile

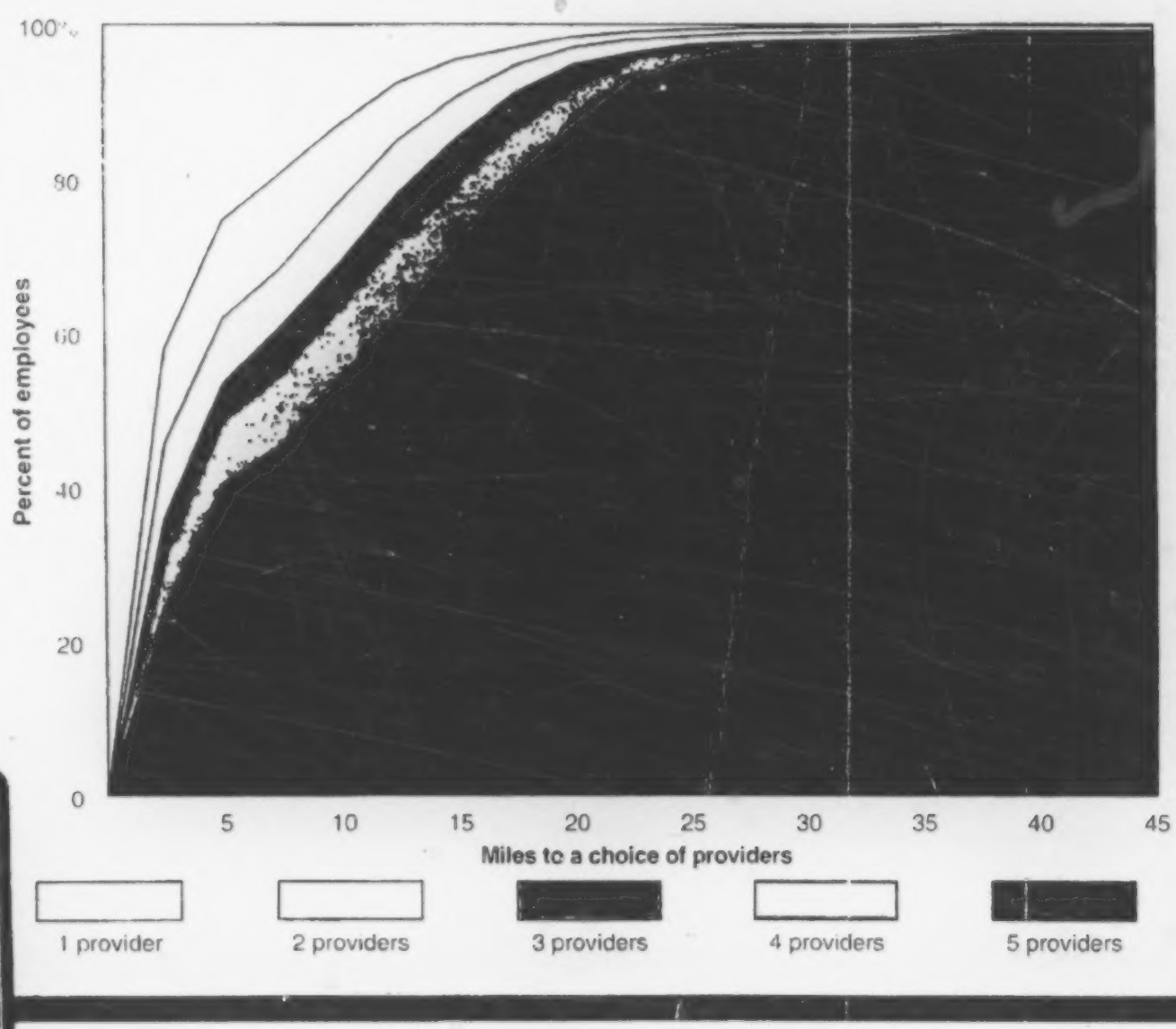
NICOLE M. NANTOIS
Deputy General Counsel
OKLAHOMA HEALTH
CARE AUTHORITY
P.O. Drawer 18497
Oklahoma City, OK 73154-0497
Nicole.nantois@okhca.org
(405) 522-7431 Telephone
(405) 530-3439 Facsimile

*Counsel of Record*

## Access standard comparison

PCP's Not Pediatrics

SoonerCare Choice Members Under 21




DEFENDANT'S EXHIBIT 19

## Average distance to a choice of providers

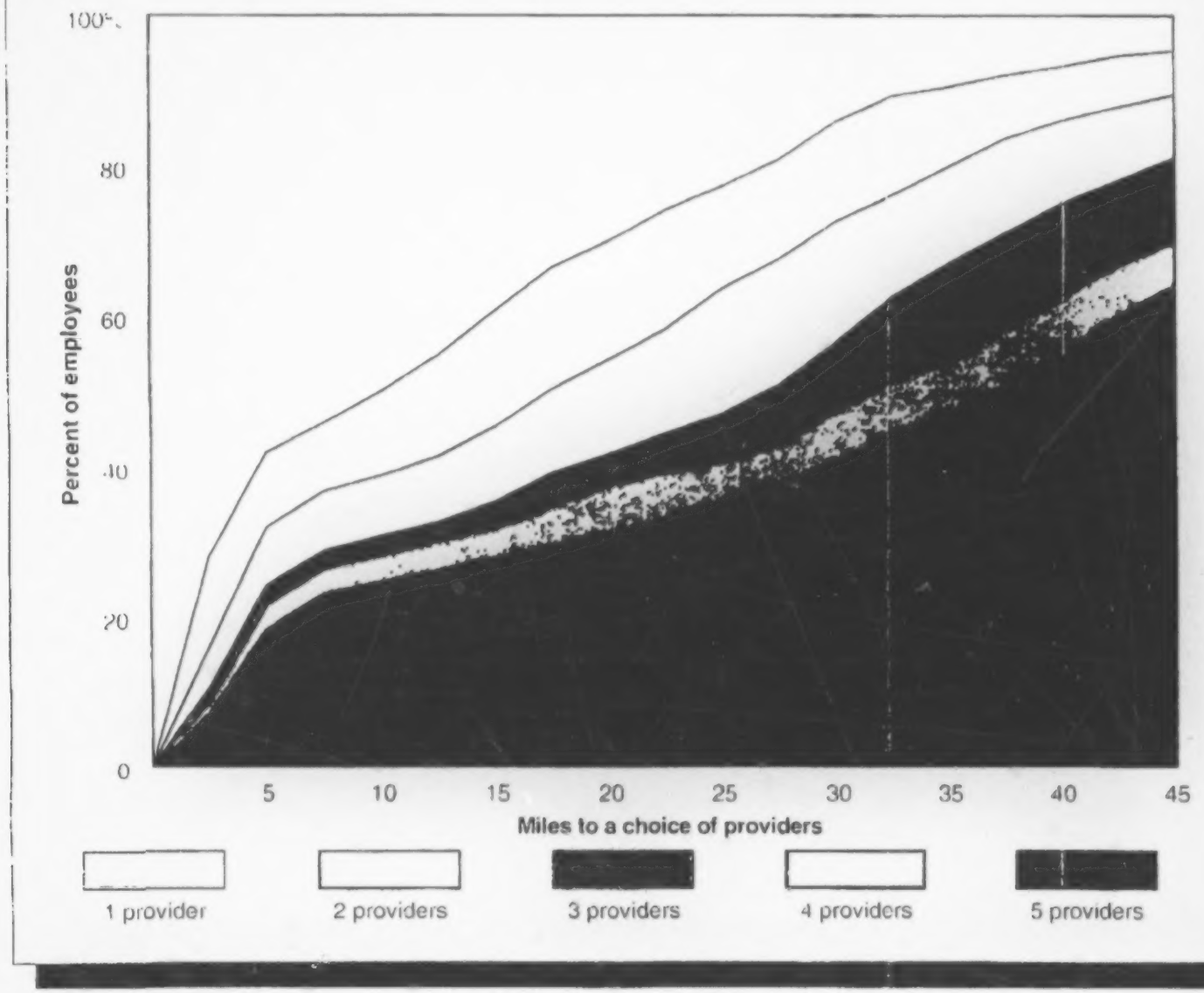
| Number of providers | Miles |
|---|---|
| 1 | 4.1 |
| 2 | 6.0 |
| 3 | 7.7 |
| 4 | 8.8 |
| 5 | 10.9 |

BEST AVAILABLE COPY

## Access standard comparison

PCP Pediatrics

SoonerCare Choice Members Under 21




## Average distance to a choice of providers

| Number of providers | Miles |
|---|---|
| 1 | 14.4 |
| 2 | 20.8 |
| 3 | 26.8 |
| 4 | 31.2 |
| 5 | 35.5 |

**UNITED STATES COURT OF APPEALS**

**FOR THE TENTH CIRCUIT**

---

OKLAHOMA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS (OKAAP), et al.,

Plaintiffs-Appellants-Cross-Appellees.

v.

MICHAEL FOGARTY, Chief Executive Officer of the Oklahoma Health Care Authority (OHCA), et al.,

Defendants-Appellees-Cross-Appellants,

AMERICAN ACADEMY OF PEDIATRICS; AMERICAN MEDICAL ASSOCIATION, and OKLAHOMA STATE MEDICAL ASSOCIATION,

Amici Curiae.

Nos. 05-5100 & 05-5107

---

ORDER

Filed February 5, 2007

---

Before **TACHA**, Chief Judge, **BRISCOE**, and **HARTZ**, Circuit Judges.

---

Appellants' petition for rehearing is denied.

The petition for rehearing en banc was transmitted to all of the judges of the court who are in regular active service. As no member of the panel and no judge in regular active service on the court requested that the court be polled, that petition is also denied.

Entered for the Court
ELISABETH A. SHUMAKER, Clerk

by: /s/ _____
Deputy Clerk

42 C.F.R. § 435.911 Timely determination of eligibility.

(a) The agency must establish time standards for determining eligibility and inform the applicant of what they are. These standards may not exceed –

(1) Ninety days for applicants who apply for Medicaid on the basis of disability; and

(2) Forty-five days for all other applicants.

(b) The time standards must cover the period from the date of application to the date the agency mails notice of its decision to the applicant.

(c) The agency must determine eligibility within the standards except in unusual circumstances, for example –

(1) When the agency cannot reach a decision because the applicant or an examining physician delays or fails to take a required action, or

(2) When there is an administrative or other emergency beyond the agency's control.

(d) The agency must document the reasons for delay in the applicant's case record.

(e) The agency must not use the time standards –

(1) As a waiting period before determining eligibility; or

(2) As a reason for denying eligibility (because it has not determined eligibility within the time standards).

---

42 C.F.R. § 435.930 Furnishing Medicaid.

The agency must –

(a) Furnish Medicaid promptly to recipients without any delay caused by the agency's administrative procedures;

(b) Continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible; and

(c) Make arrangements to assist applicants and recipients to get emergency medical care whenever needed, 24 hours a day and 7 days a week.

36 Fed. Reg. 3860 (Feb. 27, 1971)

## Title 45 – PUBLIC WELFARE

### Chapter II – Social and Rehabilitation Service (Assistance Programs), Department of Health, Education, and Welfare

### PUBLIC ASSISTANCE PROGRAMS

Notice of proposed rule making was published in the FEDERAL REGISTER on June 5, 1970 (35 F.R. 8780), setting forth, for transfer from the Handbook of Public Assistance Administration to the Code of Federal Regulations, requirements and provisions for the public assistance programs under the Social Security Act. After consideration of the views presented by interested persons, certain changes have been made.

1. The requirements for annual review of the State plan (§ 205.5(a)) and for an annual multiyear program and financial plan (§ 205.6) have been deleted;

2. The policy on safeguarding information (§ 205.50) has been clarified and strengthened;

3. The standard of promptness for determining eligibility and furnishing assistance (§ 206.10(a)(3)) now applies to the period from the filing of the application to the mailing of the first check;

4. Changes are made in the advance notice policy (§ 206.10(a)) for consistency with proposed fair hearings regulations;

5. The policy on determination of disability (§§ 233.80 and 248.80) is changed to clarify when "homemaking" – rather than gainful employment – is the appropriate test.

(Other changes in this policy are under consideration for issuance as proposed rule making.)

6. Factors specific to AFDC (§ 233.90) now include the definition of parent, previously published as § 203.1;

7. A new optional group for title XIX (Medicaid) coverage, based on the cost of child care, is added to § 248.10.

In addition, notice of proposed rule making was published on December 3, 1970 (35 F.R. 18402), to provide that applicants for and recipients of public assistance may be accompanied by other individuals in their contacts with the agency, if they so wish. After consideration of comments received, minor clarifying and editorial changes have been made.

Accordingly, the following amendments are made to Chapter II of Title 45 of the Code of Federal Regulations:

## PART 203 – DEPRIVATION OF PARENTAL SUPPORT OR CARE

1. Part 203 is vacated and reserved. The content of § 203.1 has been transferred to and incorporated as § 233.90(a) of Part 233.

## PART 204 – GENERAL ADMINISTRATION – SOCIAL AND REHABILITATION SERVICE GRANT PROGRAMS

2. Part 204 is added as follows:

§ 204.1 Submittal of State plans for Governor's review.

A State plan under title I, IV-A, IV-B, X, XIV, XVI, or XIX of the Social Security Act, section 5 or 15 of the

Vocational Rehabilitation Act, title I of the Mental Retardation Facilities and Community Mental Health Centers Construction Act, title III of the Older Americans Act, or title I of the Juvenile Delinquency Prevention and Control Act of 1968, must be submitted to the State Governor for his review and comments, and the State plan must provide that the Governor will be given opportunity to review State plan amendments and long-range program planning projections or other periodic reports thereon. This requirement does not apply to periodic statistical or budget and other fiscal reports. Under this requirement, the Office of the Governor will be afforded a specified period in which to review the material. Any comments made will be transmitted to the Social and Rehabilitation Service with the documents.

(Sec. 1102, 49 Stat. 647, 42 U.S.C. 1302; sec. 7(b), 68 Stat. 658, 29 U.S.C. 37(b); sec. 139, 84 Stat. 1323, 42 U.S.C. 2677b; sec. 101 et seq., 79 Stat. 218-226, 42 U.S.C. 3001 et seq.; and secs. 131 and 401, 82 Stat. 466, 471, 42 U.S.C. 3841, 3881)

---

**PART 205 – GENERAL ADMINISTRATION – PUBLIC ASSISTANCE PROGRAMS**

3. Part 205 is amended to add the following sections:

§ 205.5 Plan amendments.

(a) *State plan requirements.* A State plan under title I, IV-A, X, XIV, XVI, or XIX of the Social Security Act must provide that the plan will be amended whenever necessary to reflect new or revised Federal, statutes or regulations, or material change in any phase of State law, organization, policy or State agency operation.

(b) *Federal financial participation.* Except where otherwise provided, Federal financial participation is available in the additional expenditures resulting from an amended provision of the State plan as of the first day of the calendar quarter in which an approvable amendment is submitted or the date on which the amended provision becomes effective in the State, whichever is later.

§ 205.30 Methods of administration.

State plan requirements: A State plan under title I, IV-A, X, XIV, XVI, or XIX of the Social Security Act must provide for such methods of administration as are found by the Secretary to be necessary for the proper and efficient operation of the plan.

§ 205.40 Quality control system.

State plan requirements: A State plan under title I, IV-A, X, XIV, XVI, or XIX of the Social Security Act must provide for a system of quality control in accordance with Federal specifications. Under this requirement:

(a) The State agency's system of quality control must be implemented through:

(1) Application of one of the sampling methods prescribed by the Social and Rehabilitation Service;

(2) Use of federally prescribed schedules and instructions, or schedules which provide for identical information as a minimum;

(3) Field investigations, including a personal interview in all cases which fall within the sample of the active caseload and, as necessary, with persons who have been

denied assistance or whose assistance has been terminated;

(4) Use of qualified staff under appropriate direction;

(5) Reporting to the Federal Government as prescribed.

(b) The State agency must submit to the Social and Rehabilitation Service, in accordance with Federal instructions:

(1) A brief description of the State's sampling plan including the system of selecting the sample;

(2) The State's plan for use of staff; and

(3) The plan for analysis of and action on findings.

§ 205.50 Safeguarding information.

(a) *State plan requirements.* A State plan under title I, IV-A, X, XIV, XVI, or XIX of the Social Security Act, except as provided in paragraph (b) of this section, must provide that:

(1) Pursuant to State statute which imposes legal sanctions:

(i) The use or disclosure of information concerning applicants and recipients will be limited to purposes directly connected with the administration of the program. Such purposes include establishing eligibility, determining amount of assistance, and providing services for applicants and recipients.

(ii) The State agency has authority to implement and enforce the provisions for safeguarding information about applicants and recipients;

(iii) Publication of lists or names of applicants and recipients will be prohibited.

(2) The agency will have clearly defined criteria which govern the types of information that are safeguarded and the conditions under which such information may be released or used. Under this requirement:

(i) Types of information to be safeguarded include but are not limited to:

(*a*) The names and addresses of applicants and recipients and amounts of

* * *

---

38 Fed.Reg. 33380 (Dec. 3, 1973)

**Title 45 – Public Welfare**

**CHAPTER II – SOCIAL AND REHABILITATION SERVICE (ASSISTANCE PROGRAMS), DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE**

**MEDICAID**

**Eligibility Requirements**

Notice of proposed rulemaking regarding Medicaid eligibility requirements was published in the FEDERAL REGISTER on June 21, 1973 (38 FR 18309). The proposal related to the following provisions of Pub. L. 92-603, Social Security Amendments of 1972:

1. *Section 255.* Requires that entitlement to Medicaid be retroactive to the third month prior to the month of application if the applicant received medical or remedial care and was (or would have been) eligible for Medicaid at the time he received it (§ 206.10(a)(6)).

2. *Section 249E.* Requires that individuals eligible for financial assistance and entitled to OASDI benefits for August 1972 who become ineligible for financial assistance solely because of the 20-percent increase in OASDI benefits shall continue to be eligible for Medicaid through June 1975, as though they were "categorically needy", i.e. still eligible for a money payment (§§ 248.10(a)(1) and (b)(3); 248.20(b) and (c)(2)).

3. *Section 209(a).* Requires that certain AFDC families which become ineligible for financial assistance solely because of increased income from employment shall continue to be eligible for Medicaid for 4 months. (§§ 248-10(a)(1) and (b)(4); 248.21(b) and (c)(2)).

4. *Section 299B.* Provides Federal financial participation in expenditures for inpatient psychiatric care for individuals under 21, and, under certain circumstances, up to age 22 (§ 248.10(b)(2)(iv) and (d)(2)(i); 248.30(b)(1); and 248.60(a)(2) and (3)(iv). (Other proposed regulations prescribing requirements for providing such care under the Medicaid program will be published with opportunity for public comment in the near future.)

5. *Section 230.* Repealed section 1903(e) of the Act, which required States to gradually broaden the scope of care and services and liberalize eligibility requirements under their Medicaid plans so that, by July 1, 1977, comprehensive care and services would be furnished to substantially all individuals who met the eligibility

conditions with respect to income and resources under the State plan. Federal financial participation for certain administrative costs has accordingly been terminated.

Comments were received from eight respondents, dealing primarily with provisions required by law, i.e., retroactive coverage (including deceased persons) and continued coverage of AFDC families. It was suggested that uniform eligibility requirements be established; however, this would require legislation. One comment stated that families receiving continued coverage should be treated as categorically needy only if the State has no medically needy program. This change has not been made since all families in like circumstances must be treated similarly. Another respondent believes that OASDI beneficiaries should be covered whether or not the State's Medicaid plan included them as an optional group in August 1972. However, the intent of the legislation was to protect current recipients rather than to bring in new ones. A county official objected to the termination of Federal matching for certain administrative costs, while another comment predicted that termination of such matching would force on the States "a massive accounting problem from which any potential savings will most probably be more than offset by increasing administrative costs." Such termination is required, however, since the statutory support for such matching has been removed.

The following changes have been made in the regulations to clarify the language or to incorporate changes made necessary by new legislation.

(1) An effective date has been added to subparagraph (6) of § 206.10(a) to clarify that this requirement is retroactively effective.

(2) Subparagraphs (3) and (3)(ii)(B) of § 248.10(b) have been amended by inserting "July 1, 1975" in place of "October 1, 1974" as required by Pub. L. 93-66, which was enacted after the proposed rulemaking was published.

(3) Subparagraphs (3)(ii)(A)(*2*) and (B)(*1*) and (*2*) of § 248.10(b) have been clarified.

(4) An effective date has been added and other modifications made to § 248.10(d) to clarify that the limitation on Federal matching is retroactively effective.

Chapter II, title 45 of the Code of Federal Regulations, is amended as set forth below:

## PART 206 – APPLICATION, DETERMINATION OF ELIGIBILITY AND FURNISHING ASSISTANCE – PUBLIC ASSISTANCE PROGRAMS

1. Section 206.10 is amended by revising paragraph (a)(6) to read as follows:

§ 206.10 Application, determination of eligibility and furnishing assistance.

(a) *State plan requirements.* * * *

(6) Entitlement will begin as specified in the State plan, which (i) for financial assistance must be no later than the date of authorization of payment and, for purposes of Federal financial participation, may be as early as the first of the month in which an application has been received and the individual meets all the eligibility conditions, and (ii) for medical assistance, effective July 1, 1973, must be no later than the third month prior to the month of application for financial or medical assistance if the individual was eligible, or on application (regardless of whether or not the individual was alive at the time of

application) would have been eligible on the date that he received medical care or services; and may be as early as the first day of such third prior month if he was eligible at any time in such month.

* * *

## PART 248 - COVERAGE AND CONDITIONS OF ELIGIBILITY FOR MEDICAL ASSISTANCE

2. Section 248.10 is amended, as set forth below, by revising paragraphs (a)(1) and (b)(2)(ii) and (iv); renumbering paragraph (b)(3), (4), and (5) as (b)(5), (6), and (7) respectively, revising the renumbered paragraph (b)(7), and adding new paragraphs (b)(3) and (4); and revising paragraphs (d)(1) and (2).

§ 248.10 Coverage and conditions of eligibility for medical assistance.

(a) *Definitions.* – When used in this part:

(1) The term "categorically needy" refers to an Individual who is receiving financial assistance under the State's approved plan under title I, IV-A, X, XIV, or XVI of the Social Security Act, or is in need under the State's standards for financial eligibility in such plan. (See § 233.20 of this chapter. See also paragraphs (b)(3) and (4) of this section for individuals who are treated as if they were "categorically needy".)

(2) The term "medically needy" refers to an individual whose income and resources equal or exceed the State's standards under the appropriate financial assistance plan but are insufficient to meet his costs for medical insurance premiums and for necessary medical and remedial care and services recognized under State law but

not encompassed in the State plan for medical assistance, plus his costs for medical and remedial care and services included in the State plan.

(b) *State plan requirements.* – A State plan under title XIX of the Social Security Act must:

(1) Provide that medical assistance will be available to the following groups of "categorically needy" persons:

(i) All individuals receiving aid or assistance under the State's approved plans under titles I, IV-A, X, XIV, and XVI of the act; this includes all individuals who (*a*) are essential persons under the State plan and (*b*) could be recipients, if the State plan were as broad as permitted for Federal financial participation;

(ii) All individuals under 21 who are, or would be, except for age or school attendance requirements, dependent children under the State's approved AFDC plan;

(iii) All persons who would be eligible for aid or assistance under one of the other approved State plans except for any eligibility condition or other requirement in such plan that is specifically prohibited in a program of medical assistance under title XIX of the act.

(2) Specify any other groups of "categorically needy" individuals (not covered by subparagraph (1) of this paragraph), that will be included in the program. These may include:

(i) Persons who meet all the conditions of eligibility, including financial eligibility, of one of the State's other approved plans, but have not applied for such assistance.

**DEFENDANT'S EXHIBIT 27**

***SoonerCare Choice*** Provider Handbook

**Tabs and Contents** **Page**

**Introduction**
***SoonerCare* Choice** ..... 1
Contract Relationships ..... 2
Quality Assurance ..... 3

**Access to Care**
PCP/CM Responsibilities ..... 1
Emergency Room ..... 1
Primary Care ..... 2
Additional Requirements ..... 3
Attachment A – Primary Care Capitated Services ..... 4
ER Policy Letter, OHCA 2001-01

**Care Management**
Definition/Contact Information ..... 1

**Member Enrollment**
Eligibility and Certification ..... 1
Choosing a PCP/CM ..... 2
Capacity (Number of Members per PCP/CM) ..... 2
Changing PCP/CMs ..... 3
Dismissal Requests ..... 4
Exhibits:
Notice of Expiration of Medical Eligibility
Recertification of Eligibility for ***SoonerCare*** Health Benefits (FSS-BR1-MED)
Provider Change Request Form

**Referrals**
***SoonerCare* Choice** Referrals ..... 1
Referrals to Other PCP/CMs ..... 2
Referrals Not Required ..... 2
Inappropriate Referrals ..... 2

Payment of Referred Services ..... 3
Documenting the Medical File ..... 3
Unauthorized Use of Provider Numbers ..... 3
Referral Form, instructions, Sample ..... 4

**EPSDT**
Schedule of EPSDT Services ..... 1
Additional Requirements ..... 1
EPSDT Bonus Payment ..... 2

**Getting Paid**
Capitation Payments ..... 1
Encounter Claims ..... 1
EPSDT Bonus Payment ..... 2
Stop-Loss for TANF Members ..... 2
ABD Member Bridge Payment ..... 3
Immunization Incentive Payment ..... 3
Enhanced Payment for SP/ABD or SP/TANF Case Management ..... 3
Attachment C-Capitation Rates ..... 4
Exhibits:
OHCFA 1500 Claim Form
HCFA 1500 Instructions
Where to Send ..... 8
***SoonerCare* Choice** Enrollment Roster ..... 9
***SoonerCare* Choice** Capitation Payment Listing ..... 11
Claims Paid Remittance Statement ..... 13
Timely Filing Policy Letter, OHCA 2001-33 ..... 14

**Provider Help**
EVS Eligibility Verification System ..... 1
Nurse Advice Line ..... 2
In-Office Resources ..... 3

**Member Help**
Education/Information ..... 1
Nurse Advice Line ..... 2
***SoonerCare*** Helpline ..... 3

**SoonerRide** (Non-emergency Transportation Service) ..... 4

**Quick Reference**
Telephone Listing..... 1
Call Tree..... 2

**Additional Information**
Glossary/Definitions..... 1
FAQS (Frequently Asked Questions) ..... 4
***SoonerCare*** Health Benefits Application (See website version)
***SoonerCare* Choice** Member Handbook (See website version)

---

**ATTACHMENT C**
**Monthly Capitation Rate Schedule**
**Effective for 2002, 2003 & 2004**

**TANF Members**

| Rate Category | Age | Base Rate | Case Management | Total Cap. Payment |
|---|---|---|---|---|
| Male/Female | <1 | $ 37.18 | $ 3.00 | $ 40.18 |
| Male/Female | <2 | $ 18.78 | $ 3.00 | $ 21.78 |
| Male/Female | 2 – 5 | $ 15.52 | $ 2.00 | $ 17.52 |
| Male/Female | 6 – 14 | $ 9.19 | $ 2.00 | $ 11.19 |
| Female | 15 – 20 | $ 12.66 | $ 2.00 | $ 14.66 |
| Male | 15 – 20 | $ 6.93 | $ 2.00 | $ 8.93 |
| Female | 21 – 44 | $ 10.59 | $ 2.00 | $ 12.59 |
| Male | 21 – 44 | $ 8.48 | $ 2.00 | $ 10.48 |
| Male/Female | >44 | $ 12.02 | $ 2.00 | $ 14.02 |

**ABD MEMBERS**

| Rate Category | Age | Base Rate | Case Management | Total Cap. Payment |
|---|---|---|---|---|
| Male/Female | <1 | $ 37.18 | $ 3.00 | $ 40.18 |
| Male/Female | <2 | $ 21.49 | $ 3.00 | $ 24.49 |
| Male/Female | 2 – 5 | $ 21.49 | $ 3.00 | $ 24.49 |
| Male/Female | 6 – 14 | $ 21.49 | $ 3.00 | $ 24.49 |
| Female | 15 – 20 | $ 21.49 | $ 3.00 | $ 24.49 |
| Male | 15 – 20 | $ 21.49 | $ 3.00 | $ 24.49 |
| Female | 21 – 44 | $ 19.76 | $ 3.00 | $ 22.76 |
| Male | 21 – 44 | $ 19.76 | $ 3.00 | $ 22.76 |
| Male/Female | >44 | $ 19.76 | $ 3.00 | $ 22.76 |

Please note that these rates will be paid for the capitated services listed in the benefit package. Covered services provided which are not in the capitated benefit package will be paid on the current Medicaid fee-for-service schedule.

Individuals who are dually eligible for Medicare/Medicaid are not part of the program at this time.